FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

State Attorney's Office
1350 NW 12th Avenue
4th Floor Conference Room
Miami, Florida

April 14, 2011
As Advertised

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Board of County Commissioners

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CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 14, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Offices of The Beacon Council, 80 S.W. 8th Street, Suite 2400, Miami, Florida, on Thursday, April 14, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata, Vice Chairperson Susan Dechovitz, and Members: Manuel P. Anton III, Dr. Michael Barron, Martha Baker, Ed Feller, Brian Keeley, Marisel Losa, Linda Quick, Steven Pinkert, Sharon Pontious, Lillian Rivera, Donna Shalala, Steven Sonenreich, (Members Jose Cancela, Lee Chaykin, Robert Johnson, M. Narendra Kini, Steven Marcus, and Ana Mederos were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Karon Coleman and Laura Llorente; Charles Anderson, S. Donna Palmer, Angie Martinez, and Noel Aranha, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Chairman Juan Zapata called the meeting to order at 3:02 p.m.

II. OPENING REMARKS:
Chairperson Juan C. Zapata advised members that he had placed additional items on today's (4/14) agenda. He invited HGT members to also place items pertaining to governance and the efforts of this Task Force on the agenda by submitting the information to Ms. Palmer in the Commission Auditor's Office. Mr. Zapata suggested that members look at "The Privatization of Public Hospitals" article on the Website and review the various processes and procedures used by hospitals.

Mr. Zapata reminded members of the need to determine the type of recommendations they would make to the County Commission, and noted he would like the Task Force to ratify its submission at the May 12, 2011 HGT meeting. He expressed his preference to propose several options for the County Commission to consider; however, the Task Force could decide to present one option or multiple scenarios.

III. PRESENTATIONS

A. The Sibery Group, LLC
Mr. Duane Fitch, Senior Partner and Chief Financial Officer, The Sibery Group, LLC, appeared before the Task Force and provided a brief historical overview and introduction of The Sibery Group organization. He presented a PowerPoint presentation covering the following topics: Importance of Taskforce; Immediate Issues Independent of Governance Discussion; Current Governance Model; Governance Effectiveness vs. Governance Structure; Operational Issues Universal to All Governance Models; PHT Observation; and Miami-Dade County Observation. Mr. Fitch emphasized the importance of a governance dashboard to be in place.

Dr. Edward Feller concurred with Mr. Fitch's point regarding the Public Health Trust (PHT) board members' lack of experience in hospitals, management, healthcare, and finances. He also agreed that the political influence of the Board of County Commissioners was detrimental to the success of the hospital board.

IV. TELECONFERENCE INTERVIEWS

A. Boston Medical Center

Mr. Tom Traylor, Vice President of State, Local, and Federal Programs, Boston Medical Center, briefly highlighted his credentials, followed by a historical overview of the legal structure, governance, and mission of the Boston Medical Center (BMC) via teleconference. Referencing the information included in today's agenda package that he provided prior to this meeting, Mr. Traylor discussed the hospital's financial background, affiliations, and composition of the Board of Trustees. He indicated the reason BMC created a change in its governance structure was to address the hospital's limited ability to be flexible and competitive, due to being part the City.

Mr. Traylor provided the following responses to questions presented by HGT members Lillian Rivera, Martha Baker, and Donna Shalala:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

Improvement in quality, growth in volume, ability to improve additional conditions, and growth in market share (20,000 admissions to 30,000); still challenged in patient satisfaction rate; overall growth in revenue, notwithstanding current challenges due to the Massachusetts Healthcare Reform changes.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

Motivation for governance change was to gain flexibility in terms of having the ability to retain own revenue, as a typical business versus the government being on a cash basis, with the ability to invest and add more revenue.

There was a simultaneous governance structure and merger, in which the private hospital had much more of a Medicare payer mix and the DCH had a typical Medicaid pre-care mix, and when they were combined, the absolute safety net hospital became more diversified with more commercial or Medicare mix than a typical safety net hospital. Overall, the combined system grew and the payer mix was still at about 30 percent Medicaid and still 10 percent uninsured, even with Massachusetts Healthcare Reform. Over half the patients were low-income patients.

3. What impact did the governance change have on your mission and how is that measured?

The Chief of Medicine was on both sides of the street so already shared combined medical services, which helped get through problems with other mergers. Overall, a plus on both quality and teaching programs to have everything combined. City Hospital was originally at 10 percent Medicaid or mix, but with the combined hospitals together, it was approximately 30 percent Medicare.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

Under the old structure, the hospital was basically run by the City and evaluated through annual budget reviews; currently, a 30-member Board, consisting of various subcommittees (Finance, Audit, Nominating), evaluates its performance in governance, as well as the effectiveness of the hospital's performance team, including the Chief Executive Officer (CEO). One annual meeting was mandated and statute requirements that BMC remains true to the historic mission as a safety net hospital. There was no actual scorecard for measuring effectiveness. The 30-member Board was manageable with generally 20-25 attendees at bi-monthly meetings; staffing being relatively small.

5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?

Either the governance change and/or the merger or both in combination worked to make BMC significantly better, finically stronger and larger, and a stronger hospital than City Hospital alone was, by all measures. The same results could not have been achieved under the existing governance structure.

The current governance structure assumed complete authority over the personnel system and legal processes.

Mr. Traylor noted the Strong Mayor observed other hospitals in Boston merging and championed this merger as being better for Boston City Hospital. Some individual City Council members expressed opposition; however, the Boston Health Net Centers supported this merger as a way to have a stronger safety net hospital.

Mr. Traylor noted that the hospital's budget was approximately $1 billion with approximately $100 million un-reimbursed cost and approximately $200 million un-reimbursed Medicaid cost. Admissions had been paid in various ways, largely by the Federal Government by Medicaid waivers. The State of Massachusetts maintained a Safety Net Pool that paid hospitals for the remaining uninsured which provides a revenue stream for BMC. During the current year, BMC lost approximately $25 million of the $1 billion budget and anticipated the same lost for FY 2010-11. BMC's market share within Boston had grown slightly since the merger; however, so had most of the other teaching

hospitals in Boston. The Boston Health Net's governance was separate from the BMC Board; the members were Boston Medical Center, Boston University Medical School, and 15 Health Centers. The Boston Health Net Centers were Federally Qualified Health Centers and teaching was conducted at those centers.

Regarding labor opposition to merger, Mr. Traylor stated some pre-agreements protecting pensions and other benefits allowed the merger to go forward. The same unions were retained in the merger, including two separate nursing unions from the two predecessor hospitals. Composition of the 30-member Board as representation of the mission and the enabling legislation and state statute were instrumental in addressing the labor issues.

B. Harborview Medical Center

Ms. Johnese Spisso, Chief Health Systems Officer, Harborview Medical Center (HMC), provided an extensive historical overview of the HMC via teleconference. Following this presentation, she gave the following responses to questions from HGT members Lillian Rivera, Martha Baker, and Donna Shalala:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

Using the intellectual, capital, and talent of University of Washington and world class UW physicians to staff the medical centers. Two large medical centers in close proximity to UW, compete for paying patients. Among the 50th percentile in patient satisfaction rating. UW Medical Center and Medical School were owned by the State and Harborview was owned by the County and managed by the UW.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

Harborview was struggling financially and with quality of care in 1970, which led to consideration of governance change.

3. What impact did the governance change have on your mission and how is that measured?

All physicians employed at Harborview are members of UW Physicians; however, the community physicians from throughout the region, refer physicians.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

Governance consists of: a 13-member Board of Trustees governs the medical center and is responsible for fiduciary matters, conducts annual evaluation of its performance, produces an annual priority report to the Board and the community; an Executive

Director employed by UW, who reports to Chief Health System Officer and the Board of Trustees; and a UW Medicine Board. Trustees serve three consecutive three-year terms.

Regarding bond issue, a major institutional master plan is updated every ten years and decisions are made with the Board to do expansions or upgrades, and following approval by the County Council a bond initiative can be issued. The State went to collective bargaining approximately six years ago and prior to that there were civil service contracts. Currently five labor unions existed throughout their health system and the contracts were negotiated through UW Human Relations and Labor Relations. There were no longer any civil service contracts. UW Medicine Advancement Office by which employees does fundraising for every aspect of their system, which collects approximately $6 million per year to support quality unfunded care.

Harborview does not receive compensation from the County to provide jail health services. The UW complies with the state Sunshine Act which presents a challenge at times, but has not hurt the hospital's ability to function.

V. DISCUSSION ITEMS

A. Resignation Letter from Dr. Mark C. Rogers

B. Juniper Advisory – Firm Overview

VI. OTHER MATTERS

Chairperson Zapata requested feedback from Task Force members regarding how to move forward with development of the recommendations. He asked the Commission Auditor's staff to provide ideas on how to structure the final recommendations, and based on that, the HGT could submit their ideas. In response to Mr. Zapata's inquiry of who would write the actual document, Commission Auditor Charles Anderson informed that staff member Gary Collins would be responsible for writing the recommendation document.

Chairperson Zapata expressed concern with individual members providing information to members of the media, and it was the consensus of the Task Force that the media obtain its information by attending meetings and/or accessing the HGT Website.

Dr. Shalala recommended development of the recommendations should begin with the concept reflected on the Working Draft, A. Governing Board and Organizational Characteristics, 2. A governance model that provides clear lines of accountability for the governing body to the County government and the public/Strong ethical and conflict of interest component.

Vice Chairperson concurred with Dr. Shalala's comment that everything should flow from No. 2, however, she added that something should mention "the Safety Net Mission."

Chairperson Zapata indicated that the Mission Statement should be separate and that the governance structure was basically whatever body would oversee Jackson

Hospital/Health System. He emphasized the need for that structure to have independence, and referred to the list of the 14 issues that require the County Commission's approval.

Regarding the Working Draft (List of Recommendations), members agreed to consolidate numbers 3 and 8, to modify number 5 to eliminate the first three to read "Modification to the Sunshine Laws, which allows for maintenance of a sustainable vision."

Discussion ensued regarding whether size of the Board of Trustees makes a difference. Dr. Keeley advised that the ideal Board consisted of smart people who understood healthcare organizations, i.e. business people, finance people, bankers, lawyers, etc. Following discussion, HGT members agreed that the Board should consist of no more than nine members.

HGT members asked staff to provide information regarding how the Boards of some of the organizations of interest were populated, how members were nominated/appointed, what skills were required, and what the public's role was in this process. Staff was also asked to research what types of outside entities or transition models were created to oversee that Board and the hospital's functions to ensure it stayed true to its mission.

Chairperson Zapata advised that the next meeting would be held on Thursday, April 21, 2011, at the Beacon Council Office, 80 S.W. 8th Street, Suite 2400.

VII. ADJOURNMENT

There being no further business to come before the HGT, the meeting adjourned at 5:57 p.m.

Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force